Privacy Complaint Form

Federal law requires AKDHC/PKDHC to protect the privacy of the personal health information of our patients. You have the right to complain in writing about how we use or disclose your personal health information. We cannot take action against you because of this complaint. You must submit the complaint within 180 days of when you knew or should have known that the act being complained of occurred.

Please complete the below information (any section that is left blank may delay our response to your request)

Individual Filing Complaint (Please Print)

Last name: _____ First name: _____ Middle initial: ____

Street address: _____

City: _____ State: _____ Zip code: _____

Daytime phone number: _____ Evening Phone Number: _____

Best time to reach you: _____

Consent to Disclose Your Name

Please select one of the following:

☐ I consent to my name being disclosed to investigate this complaint.
☐ I do not consent to my name being disclosed. Please note that not using your name may limit or delay our ability to investigate this complaint.

Information about Your Complaint

Name of Organization/Office/Department that your complaint is against: _____

Name of person(s) that your complaint is against: _____

Date(s) that action(s) giving rise to your complaint occurred: _____

Details of the Complaint

I have reason to believe that one or more of the following occurred:

☐ The organization/person has inappropriately disclosed my health information or other personal information.
☐ The organization/person has inappropriately used my health information or other personal information.
☐ The organization/person has inappropriately disposed of my health information or other personal information.
☐ The organization/person has inappropriately denied me or my personal representative access to my health information or other personal information.
☐ The organization/person has inappropriately denied my request to amend/correct my health information or other personal information.

☐ The organization/person has inappropriately denied my request to restrict uses and disclosures of my health information or other personal information.
☐ The organization/person has inappropriately violated the alternate communication method that I specified.
☐ The organization's privacy policies and procedures violate the law.
☐ Other (specify).

Please provide a detailed description of your complaint, including what, when, who, where, and why. You may attach additional pages or documentary evidence.

Do you have witnesses?
☐ Yes.
☐ No.

If Yes, please provide the names, addresses, and telephone numbers of your witness(es) below:

Witness name: _____ Phone number: _____

Address: _____

Witness name: _____ Phone number: _____

Address: _____

Resolution of Your Complaint

Please describe how you believe that your complaint could be resolved:

AKDHC/PKDHC may decide that your complaint does not violate the HIPAA Privacy Rule or any other applicable law or regulation, but another organization may be able to help you. Please choose one of the following:

☐ I agree to have this complaint disclosed to another organization.
☐ I do not agree to have this complaint disclosed to another organization.

All Privacy Complaints should be documented in writing and directed to the AKDHC/PKDHC Privacy Officer. Completed request forms should be mailed to the Privacy Office using the contact information below or handed to the office staff who will direct the request to the Privacy Office for you.

AKDHC Administration Attn: Privacy Officer
3333 East Camelback RD Suite 180
Phoenix, AZ 85018

Phone: 602-997-0484

Your Signature

I certify that the information on this form is true and correct to the best of my information, knowledge, and belief.

Patient or Legal Representative **Printed** Name

Patient or Legal Representative **Signature**

Date

OFFICE USE ONLY:			
Request Received By:		Date:	